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The Bleeding Nipple As a Diagnostic and Therapeutic Problem

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THE management of the woman whose complaint is that of bleeding from the nipple remains a controversial issue. Only a small fraction of women with pathological changes in the breast have any sort of external exudate from the intact nipple, and it is therefore an infrequently occurring problem in the life of the average clinician. Its significance is variously interpreted by those who have studied the problem, to the extent that some authors recommend almost routine simple mastectomy on the basis of this single symptom, while others adopt a more conservative attitude with emphasis on accurate diagnosis. Many surgeons have an erroneous impression of the ominous import of bleeding from the nipple as a presenting symptom, and employ unnecessary radical surgical measures in conformance with their irrational diagnostic approach.

The problem will be reviewed here on the basis of its statistical importance in relation to pathological changes in the breast, benign and malignant. The conclusions are drawn from the few large series of cases reported, notably by Adair, Bloodgood, Gray and Wood, Geschickter, and Campbell, supplemented by ten cases from the author's recent experience. Only bleeding from the intact nipple is considered, excluding such conditions as produce erosive or ulcerating processes in the areola itself, notably so-called Paget's disease.

That bleeding from the nipple in breast lesions is an infrequent symptom is shown by Table 1,

TABLE 1.—*Bleeding in Breast Lesions*

Lesion	No.	Bleeding	P.C.
Cancer	2460	102	4%
Benign	2917	185	6.3%

taken from Geschickter, with an incidence of 4 per cent in cancer of the breast compared to over 6 per cent in benign lesions. This is evidence of an arresting nature, on a sound statistical base of 5,300 patients, that sanguineous exudate from the nipple is frequently indication of a benign process.

Essentially, all instances of bleeding or other discharge from the nipple have their origin in papillary, hyperplastic lesions of the ductal epithelium of the breast, less commonly in the acinar elements. Thus the most common site of origin is in the central rather than the peripheral portion of the breast, in the central third of the breast and especially in the subareolar area, rather than the peripheral two-thirds. In Table 2 is shown the incidence of bleeding from papillary lesions and it should be noted that only 4 per cent of the benign acinar (peripheral)

TABLE 2.—*Bleeding in Papillary Lesions*

Lesion	No.	Age	Bleeding
Benign:			
Acinar	212	30-45	4%
Ductal	203	30-45	48%
Cancer	197	45-70	10%

lesions had bled from the nipple, while 48 per cent of the benign ductal (central) lesions presented this symptom. In contrast, only 10 per cent of all papillary forms of cancer bled externally. Campbell re-

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EDITORIALS

Vascular Surgery

The development of each of the surgical specialties has depended upon the evolution of either diagnostic or therapeutic techniques. The vaginal speculum, the cystoscope, the endoscope, encephalography, and many other technical facilities have each opened new vistas for the surgical relief of human suffering. Advances in the more fundamental fields of anesthesia, physiology, pathology, and biochemistry, and the use of the antibiotics have furnished a safe basis without which new surgical approaches might have proved too hazardous. Vascular surgery is rapidly approaching the gestation phase as an off-shoot from general surgery and it may be well now to examine its antecedents and its prospects for life in order to provide for it the best available opportunities for growth and development.

The control of hemorrhage has presented a problem since the earliest days of surgery. The ligature of arteries was mentioned by Celsus and Antyllus, although this procedure remained unknown until again brought to light by Paré. The names of the great surgeons of the past—Hunter, Sir Astley Cooper, Dupuytren, Syme, Trendelenberg, and many others—are intimately associated with the early history of vascular surgery but it was not until the introduction of the antiseptic era by Lister that the possibilities of reparative and restorative operations on blood vessels became manifest. It is interesting to note that Lister himself was the first to record, in 1875, the successful antiseptic closure of a blood vessel—the axillary vein.[3] In more recent times the great contributions of Halsted and Mont, Reid, Carrell, and others have served as milestones of progress. It was Halsted [2] who wrote, "One of the chief fascinations of surgery is the management of wounded vessels, the avoidance of hemorrhage. The only weapon with which the unconscious patient can immediately retaliate upon the incompetent surgeon is hemorrhage." Rudolph Matas today is recognized as the founder of vascular surgery, and his scholarly history of the surgery of blood vessels [4] remains a masterpiece.

Vascular surgery has hardly yet become a "specialty." The surgeons who made these advances did so only incidentally during the course of their activities in the field of general surgery. Is there room or actual need for vascular surgery as a specialty? In an address delivered before the International Congress of Medicine in London in 1913 Harvey Cushing [1] considered the significance and purpose of surgical specialties. He concluded, "The existence of the operating specialist as contrasted with the general surgeon is justified only if the former takes advantage of his opportunities to contribute to the knowledge of the disorders he specially treats." The extraordinary advances in the past two decades, both in the surgery of peripheral vascular disorders and more recently in the surgery of major blood vessels, have made it necessary for the surgeon whose prime interest is in the furtherance of the vascular field to limit his activities in order to remain productive. The more difficult and laborious the investigative techniques, whether diagnostic or therapeutic, the more sharply must the investigative surgeon limit his professional activities.

Specialization, however, must be subject to close scrutiny since there is always the danger of losing sight of the patient as a whole. It has been said that "the specialist should be a trained physician, a skilled surgeon, and something more, but he is often something else—and something less." Too much emphasis cannot be placed on the necessity for a thorough grounding in the basic sciences, medicine, and general surgery before the individual can devote his time exclusively to vascular surgery.

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NOTICES AND REPORTS

Prepaid Medical Care Plans Likely to Increase in Importance When "Recession" Comes

According to the American Hospital Association, more indigents and semi-indigents are seeking hospitalization and fewer supposedly solvent persons are paying their hospital bills.

The Institute of Life Insurance reports that the consuming public is now going into debt twice as fast as ever before.

These items published in a recent issue of "Medical Economics" may or may not be harbingers of the much feared "bust"—but no harm would come from assuming that they were. For, no matter what it is called—"bust," "recession," "depression" or "economic adjustment"—the medical profession will feel its effects first. In the average household "time payments" have a higher priority than the doctor's bill. The new car or the quick freezer bought "on time" will be repossessed if not paid for on time—but the doctor's bill can be put aside for better days.

It would not be wise, accordingly, for the physician to disregard any sign pointing to a tightening economic condition. Today, before it is too late, he should look to his credits and check up on his collections with the same care that a bank would give them, under similar circumstances. And perhaps now might be the right time to reappraise the value of medically sponsored prepayment care plans as a protection against loss of income.

In boom times we know that the best fees that the plans can offer *look* modest indeed, when measured against the rich potential of the bulging consumer pocketbook. But when the consumer's cash reserves are gone and he is living from pay check to pay check (as many salaried workers are today), the scheduled fees are not so bad—not so bad from several angles.

In the first place the plans are usually in a better cash position during a period of falling prices than they ever are during a period of inflation. Their ability to pay higher fees is enhanced accordingly.

Another factor to be considered is the rapid increase in medical indigency when depression takes hold. A larger percentage of the physician's patients will be unable to pay for medical care. Membership in prepayment plans may fall off, too, when public income is curtailed—but the more responsible residents of every community *who are members of prepayment plans* will retain their membership despite curtailment of income. Pride, prestige in the community and common sense all act toward the retention of medical care protection in a time of economic uncertainty. If the emergency is severe the physician will find the people who have kept their medical care coverage the most desirable of patients. They will not require fourth notices of balances due, for example.

These factors concern the physician as an individual. There is another that will affect the profession as a whole. It is the effect that a depression will have upon the sponsors of political medical care schemes.

If a larger portion of the population becomes medically indigent, a hue and cry for an emergency control bill can be expected. It might even be attached as a rider to a general relief measure. And, if proposed, it will have an excellent chance of passing. Certainly the indigents would not oppose it. The organized labor group would most certainly support it. As an alternative to serving many without compensation, even some of the physicians might vote for it.

The danger of such emergency legislation is not in its intent, of course, but in its slap-bang construction. Normally it does not receive adequate debate. Under the pressure of need it is usually rushed through without full determination of its fitness to do the job. It frequently contains implications that can be exploited and bugs that cannot be eliminated. Moreover, it is most unlikely that the fees paid to physicians under it would be higher than those paid by existing medically sponsored plans.

Why then invite the risks of such legislation?